N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Marion

Township: ..... or Village: ..... or City: Hannibal (NO. Levering Hospital 6 Ward)

Registration District No. 5247 Primary Registration District No. 3039

File No. 36800 Registered No. 286

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary C. Kennedy.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Jan. 28, 1886 (Month) (Day) (Year)

AGE: 17 yrs. 9 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): " " G.O.

BIRTHPLACE (City or town, State or foreign country): Rockport Ill.

PARENTS
NAME OF FATHER: John C. Rogers
BIRTHPLACE OF FATHER (City or town, State or foreign country): Not known
MAIDEN NAME OF MOTHER: Virlina Hall
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ralls Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thayer Kennedy

(ADDRESS) Hannibal Mo

Filed Nov 8, 1913. M T Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 7, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1913, to Nov 7, 1913, that I last saw her alive on Nov 6, 1913, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Pernicious Vomiting in Pregnancy

(Duration) yrs. 3 mos. ___ ds.

Contributory (SECONDARY) Tuberculosis (Duration) yrs. 3 mos. ___ ds.

(Signed) A. L. Shantes M. D.

Nov 7, 1913 (Address) Hannibal Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: Nov. 9, 1913.

UNDERTAKER: Wm. M. Smith ADDRESS: Hannibal Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory. The* material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Marion

Township _____ or Village _____ or City Hannibal (NO. _____ St.: _____ Ward)

Registration District No. 547 File No. _____

Primary Registration District No. 3029 Registered No. 286

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary E. Kennedy

PERSONAL AND STATISTICAL PARTICULARS

SEX X COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 11-8, 1913 X M H Yause X REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-7, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 10-11, 1913, to 11-7, 1913 that I last saw her alive on 11-6, 1913, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Vomiting in Pregnancy

(Duration) _____ yrs. 3 mos. _____ ds.

Contributory (SECONDARY) Tuberculosis Lungs

(Duration) _____ yrs. 3 mos. _____ ds.

(Signed) A L Shanks M. D.

11-7, 1913 (Address) Hannibal Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191__

UNDERTAKER _____ ADDRESS _____

Original file, date NOV 1913, 19__ All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

Satisfactory Information Supplied.

WRITE IN PLAIN

N.B. Every item of information should be carefully supplied. AGE and [illegible] ied EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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